HYPNOSIS TREATMENT OF SLEEPING PROBLEMS IN CHILDREN EXPERIENCING LOSS

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Abstract

There is considerable research and clinical evidence that children who experience loss become traumatized. The results of traumatization include sleeping problems, for example difficulties in initiating sleep and sleep terrors. Psychological intervention programmes, including hypnotherapy, have been shown to have some success in helping children to overcome their sleeping problems. In the present study, a new paradigm qualitative methodology was used in which a small group of children were taught self-hypnosis to manage their sleep difficulties. Within the group, the children’s experiences of utilizing self-hypnosis at home were discussed, and a consensus reached concerning its effects. Complementary data were collected through interviews with caregivers and by completion of the Southampton Sleep Management Schedule (Bartlet and Beaumont, 1998). From the study it was concluded that young children can be taught self-hypnosis in order to manage their sleeping problems effectively. Furthermore, the present study demonstrated that children can be involved in a collaborative research group.

Key words: children, loss, qualitative methodology, self-hypnosis, sleeping disorders

Introduction

Children can be considered as traumatized if they have been bereaved through the death of one or both parents, or other significant relatives, such as siblings or friends, as a result of natural causes, accidents or suicide. Even very young children react with grief to the absence and death of family members and to the loss of people and objects that are emotionally meaningful to them, especially when unexpected such as through an accident or massive heart attack (Furman, 1974; Raphael, Field and Kvelde, 1980; Raphael, 1983). The situation of disaster bereavements, for example car accidents where the child was not involved in the impact, is likely to be very similar to other sudden, unexpected death.

Many children experience a period of sleep disturbance after disaster, often as a result of separation from their parents. They may also suffer from primary insomnia characterized by difficulties in initiating or maintaining sleep, non-restorative sleep, fear of sleeping, nightmares or night terrors. Often, these sleeping problems will compound any family difficulties, including the reduction in the number and quality of socially supportive interactions, as well as having a possible impact on memory and educational performance (Stores, 1996).
Psychological intervention

Intervention with children who have experienced bereavement aims to help the family and child to acknowledge their loss, incorporate it into their world view and reorganize their lives to take account of the loss. Family, individual and group-based interventions may be appropriate, depending upon the unique features of the case (Webb, 1993; Smith and Pennell, 1996; DeBellis, 1997).

There are many examples of hypnosis being used successfully in the treatment of sleeping disorders (Olness and Gardner, 1988; Hartland, 198; Hammond, 1990; Wester and O’Grady, 1991; Ford, 1995; Kingsbury, 1993). The techniques used in the treatment strategies include those drawn from the more direct traditional approaches as well as Ericksonian or naturalistic ones.

Karle and Boys (1987) describe a number of approaches in which children who experience bad dreams can be taught to control the content and progression of the dream (pp 176–177). Hearne (1993) suggests that hypnosis may be utilized in order to convert nightmares into lucid dreams, although his work does not specify whether this was with adults or children.

The present study

Subjects

The children participating in the study had been referred by the local Social Services Department as being suitable for treatment by an agency specializing in loss and bereavement. Since the problems that the children were experiencing commenced after their loss it was normal practice for them to be referred to South Tyneside Counselling Service which had considerable experience in working with children. The group comprised six children ranging in age from eight to 12 years (mean 9.6 years). Three children had been bereaved after the death of one parent (through a heart attack — father; a bus accident — mother; and a suicide — father); one child had lost a brother in a cycling accident; the other two children had been referred to the centre because of difficulties resulting from parental separation. All six children had experienced their losses during the previous six months. None of the children had been diagnosed with a psychiatric problem, but they all had a range of difficulties relating to sleep, relationships, school work and social behaviour. For the purposes of the present study it was decided to focus specifically on their sleeping difficulties because these were represented in all six children and were relatively easy to monitor.

Instruments

The Southampton Sleep Management Schedule (SSMS) (Bartlett and Beaumont, 1998) elicits information about the sleep disturbances of childhood, including settling and night waking patterns, early morning waking, parasomnias and nightmares (for the purposes of the present study, the frequency of nightmares and night terrors were combined, although it is recognized that they are qualitatively different). The SSMS also focuses on data pertaining to children’s developmental, medical and behavioural history, housing and bedroom arrangements, past and current medications, current management and parental attitudes to the sleep problem, parental health and stress, and help sought previously. The SSMS has 59 items and was administered in an interview with caregivers. Items related to current sleeping problems were evaluated with respect to the previous week. The present study focused on only four items:
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- Difficulties going to bed.
- Number of nights woken in the past seven days,
- Time to resettle in own bed,
- Frequency of nightmares or night terrors.

It should be noted that the SSMS is essentially a questionnaire for providing the clinician with important information useful for devising sleep management programmes rather than for making diagnostic decisions.

Method

A new paradigm research methodology was used (Reason and Rowan, 1981; Heron, 1996; Reason, 1994) involving the collaborative participation of both experimenter and subjects (the children). Validity was ensured by running sufficient action–reflection research cycles until the reported data were ‘saturated’ (that is, no ‘new’ data were reported), employing a ‘devil’s advocate’ procedure (that is, confronting the children where there appeared to be inconsistencies in their statements and/or non-verbal behaviours), generating an atmosphere of trust in the group which potentiated openness and honesty, and collecting data from primary caregivers by use of items from the SSMS.

Procedure

A meeting was arranged with the South Tyneside Counselling Centre which focuses on bereavement counselling with both adults and children. An outline of the programme was discussed and it was agreed that the research would be carried out with an existing group comprising children who had recently suffered the loss of a parent (through death or parental separation) or other close family member. The children had been attending the centre once a week for approximately four months. During these group meetings the children engaged in a number of therapeutic activities, including play, art, music, relaxation as well as other group activities. Before the first meeting with the children the researcher met the caregivers (in some cases this was the parent(s); in others a grandparent or an aunt) to explain the purposes and practicalities of the study. The caregivers were also asked to complete the SSMS.

First meeting

The first meeting, held two weeks after the meeting with the caregivers, lasted approximately two hours, and was facilitated by the primary researcher. It was structured in such a way as to engage the interest of the children. During the first part of the session (approximately 15 minutes) the children were able to play games or read followed by a ‘game’ in which they took turns to tell the group some good things that had happened during the week. Each child was also asked to say what their favourite animal was and whether they had any pets. They were then encouraged to draw their ‘sleeping problems’ followed by a brief description of the representation. All the children referred to experiencing bad dreams and nightmares with most of them saying that this was a nightly occurrence. References were also made to difficulties in going to sleep, waking up frequently, being frightened of the dark, ‘seeing’ faces or shadows in the dark, hearing ‘frightening’ noises or voices, and changing beds etc. This was helpful in augmenting the data obtained from the SSMS and provided the basis for the group hypnosis.
It was suggested to the group that it would be possible for them to go to sleep and stay asleep with pleasant and enjoyable dreams throughout the night so that they would not wake up during the night (unless they had to get up to visit the lavatory).* It was explained to the children that in order to do this they would have to engage in some preparation and practice so that it would work more effectively. The children agreed to this and seemed quite excited at the idea. Prior to this meeting the caregivers completed items on the SSMS relating to ‘night waking’ and ‘other aspects of sleep’.

Self-hypnosis
Evidence that children could readily learn techniques of self-hypnosis has already been demonstrated by the author (Hawkins et al., 1998). The children were taught a method of self-hypnosis (‘sleeping game’) utilizing their favourite place and ‘inner guide’ (Jaffe and Bresler, 1980). The children selected their favourite place, as part of a game, before the hypnosis was carried out. This approach was chosen because the age range and interests of the group were quite diverse and managing anxiety rather than the content of the dreams was much more appropriate to the group situation. The following instructions were given to the children:

Now, close your eyes as if you were just about to go to sleep so that you begin to feel all dreamy … you might notice how light you feel and perhaps even a tingling sensation as if you are sitting on a big fluffy ball of wool … And as you feel light, so you might notice that the cotton wool is like a fluffy white cloud … Would you like to go to a special or favourite and very safe outdoor place? … Then all you have to do is to imagine your fluffy floating cloud is a magic cloud car. You can steer this car quite easily and fly it to your favourite place … you land your car and look around … what can you see? What can you hear? … Is it hot or cold? … Now, as you look around you notice a very friendly animal (maybe your own pet) who comes up to you … as you stroke your friendly animal you feel extremely sleepy knowing that you can go to sleep and make all of your dreams enjoyable. And if you wake up during the night, you will remember how to go to your safe place quickly and easily in your cloud car … And when you get to your special place you will already be dreamy and sleepy so that when you stroke your friendly animal you will fall deeply asleep, very relaxed and happy … And, the more you practice, you might not even notice that you might not even wake up as you go to your special place … and there you will learn to sleep soundly all night long with enjoyable dreams. When you wake up in the morning you will feel wide awake and look forward to all the things that you have to do during the day. (Adapted from Ford, 1995, pp 204–205; Hammond, 1990, pp 253–256).

After the session a discussion with the children revealed that they had become absorbed in the experience confirming the author’s interpretation of the behavioural evidence manifested during the exercise. The children then practised this on their own and were instructed to do this every night before going to sleep. Feedback from the children suggested that they followed the general idea of the ‘script’, although there were considerable ‘interpretations’.

Second meeting
This took place two weeks later. The children were asked about their experiences relating to the ‘sleeping game’. They all said that they had performed the ‘self-hypnosis’

*The SSMS revealed that at least two of the children suffered from nocturnal enuresis.
every night and that it had helped them to get to sleep. This was confirmed by the caregivers who were instructed to encourage the children to engage in the required tasks. The children were asked to continue with the ‘sleeping game’ for a further four weeks and then meet again.

**Third meeting**

This occurred six weeks after the beginning of the treatment. Once again, the children were asked about their experiences. They confirmed unanimously what was said at the second meeting, although there was some indication that there were improvements in other aspects of their lives, such as school work. Five members of the group said that they felt less tired at school and looked forward to going there.

A meeting of the caregivers was also organized to take place after the third meeting with the children. They confirmed the conclusions reached by the children and, further, that there were improvements in concentration, behaviour and general well-being. A third completion of the relevant items on the SSMS also confirmed the positive changes (Table 1).

**Results**

At the second meeting the general consensus of the group was that:

- The ‘sleeping game’ helped them to get to sleep.
- They woke up less frequently during the night.
- When they woke they were less afraid and could easily go to sleep again (one child).
- They had fewer bad dreams (one eight-year-old boy said that he could control his dreams and ‘make’ them good).
- They felt better in the morning (one child).

**Table 1: Data from selected items of SSMS**

<table>
<thead>
<tr>
<th>Child</th>
<th>Difficulties going to bed*</th>
<th>Number of nights woken in past seven days</th>
<th>Time to resettle in own bed**</th>
<th>Frequency of nightmares/night terrors</th>
</tr>
</thead>
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<tr>
<td>A</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
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<td>2</td>
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<td>7</td>
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<tr>
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<td>4</td>
</tr>
<tr>
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<td>7</td>
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<td>38</td>
</tr>
<tr>
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<td>3.5</td>
<td>1.2</td>
<td>6.7</td>
<td>6.3</td>
</tr>
</tbody>
</table>

*0 = Not difficult; 1 = Difficult 1–3 nights (less than 1 hour); 2 = (less than 1 hour); 3 = 1–3 nights (more than 1 hour); 4 = 4–7 nights (more than 1 hour)

**0 = under 5 minutes; 1 = 5–15 minutes; 2 = 16–30 minutes; 3 = 31–60 minutes; 4 = Not possible.
• They were not afraid to go to sleep (one child reported that he no longer required a night light).

As indicated above, these results were confirmed at the third meeting and were corroborated by scores on the relevant items of the SSMS. Table 1 above provides data for each child for relevant selected items, such as difficulties going to bed, night waking, average time to resettle in own bed after waking and frequency of nightmares. This was used in order to provide confirmatory evidence of the accuracy of the children’s accounts.

Discussion

The children fully involved themselves in the ‘research’ group and the self-hypnosis treatment strategy. Although only three group meetings were held and there were no individual sessions (which were planned initially), there were reductions in the incidence of sleeping problems as indicated by the children’s verbal reports and the caregivers’ confirmations and responses on the SSMS. Of course, such improvements cannot be attributed categorically to the effects of self-hypnosis as they might have been a result of time passing or some other extraneous independent variable(s), such as the attention provided by the researcher. However, this seems unlikely given that the children had been experiencing these problems for approximately five months before the first group session. It should also be noted that the children were not receiving any other psychological or pharmacological treatments during the period of the hypnosis research. Nevertheless, further studies, including follow-up procedures, are planned in which the efficacy of hypnosis treatment will be evaluated by use of time series analysis.

Conclusions

The main conclusions from this study are that children can be taught to manage their sleeping problems effectively using self-hypnosis. They readily learned this technique and became fully involved in the ‘treatment’ process. Importantly, it was also shown that children are able to be effective agents in both the collection and synthesis of research data.

References

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